National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

LEARNING TOGETHER:
A PRACTICE FRAMEWORK FOR BUILDING ORGANIZATIONAL CAPACITY FOR HEALTH EQUITY

This document provides practical considerations for public health organizations seeking to develop their capacity to improve health equity.

ORGANIZATIONAL CAPACITY FOR HEALTH EQUITY ACTION INITIATIVE

This document has been developed as part of the Organizational Capacity for Health Equity Action Initiative (OCI). The OCI fosters learning about frameworks, strategies and organizational conditions that can enable Canadian public health organizations to develop and sustain their capacity for health equity action. The initiative uses a participatory learning approach through reviews of the literature, learning circle conversations and practice site implementation.

To learn more about the OCI, visit our website at www.nccdh.ca.

PURPOSE

This document describes a practice framework for building organizational capacity for health equity. We offer considerations for building capacity for health equity action within public health organizations.

This document is best used alongside the companion document, *A model for increasing organizational change capacity for health equity*,[1] which describes enablers and barriers to health equity–focused organizational change.

INTRODUCTION

Public health organizations have a mandate to improve and maintain the health of the population. In addition to improving health across the entire population, this goal also entails reducing systematic and unfair differences in health and social outcomes for population groups.[2] To achieve this goal, public health institutions are called to actively embed a health equity approach into the everyday workings of the organization.

Health equity means all people can reach their full health potential without systematic disadvantage based on social and economic inequities due to race, ethnicity, religion, gender, life stage, social class, sexuality, disability or other social circumstances.[3–5] Making improvements to health equity guides organizations to consider how they can contribute to improving the daily living conditions that influence health. It also encourages them to act on the social and structural determinants of health and health inequities. This involves aligning efforts with others across sectors, disciplines and communities with deep attention to the political economy and the roots of inequities.[6–10]

Organizations within the public health system need to be adequately equipped to respond to the social determinants of health and health equity.[11–15] In other words, they need adequate capacity to identify existing health inequities and direct resources for actions required to reduce these inequities.[12] They also need to build their capacity to understand the drivers of health inequities and the requisite solutions.

In response to this need, the National Collaborating Centre for Determinants of Health (NCCDH) implemented the Organizational Capacity for Health Equity Initiative (OCI). The OCI is a participatory learning initiative designed to identify frameworks, strategies and organizational conditions that can support public health organizations to improve their capacity to address health equity.[16] We developed this practice framework as a guide for organizations seeking to improve their health equity capacity. The framework identifies parts of the organizational fabric that need to be infused with equity and social justice–oriented actions. We draw on the literature regarding organizational capacity for health equity,[12,13,15,17–20] as well as learning circle discussions that were held as part of the OCI.[1]

The framework builds on previous NCCDH work and focuses on an organization's ability to fulfil public health equity roles,[3] as well as goals and approaches identified in the *Common agenda for public health equity action*.[21] This framework focuses on the *what* of change and is best used alongside the companion paper, *A model for successful organizational change capacity for health equity*,[1] which explores broader organizational conditions that support successful organizational change[22]

We encourage public health organizations to use and adapt the practice framework to meet their organization's needs.

ORGANIZATIONAL CAPACITY FOR HEALTH EQUITY AND ORGANIZATIONAL CHANGE

Organizational capacity broadly refers to the ability of an organization to function optimally so that it can meet its desired goals and objectives. Action to improve health equity needs to be "long-term, systematic and dynamic."[23(p6),14] At an organizational level, this action requires that internal systems, structures and practices are aligned with health equity goals. Specific to health equity, organizational capacity is the ability of an organization to identify and act on health equity priorities.[12] In order for this action to be effective, it is essential for proponents of health equity change to pay attention to the external context of the organization. For example, consideration should be given to how social and political forces influence the priorities of the organization, and health equity leaders should be in the position to respond to those which do not align with equity.

Building organizational capacity for health equity shifts how an organization operates; it also creates a supportive environment for practitioners to implement health equity–oriented programs and policies. As such, developing organizational capacity for health equity requires drawing on knowledge of how organizations change. Organizational change to build health equity capacity can be emergent or planned based on information about an existing or potential problem.[24] Regardless of how change begins, organizations often start with change in one or more areas of organizational capacity for health equity. An assessment of the organizational context and processes to support the desired change before beginning will facilitate the success of the endeavour and identify priority areas for change.[19]

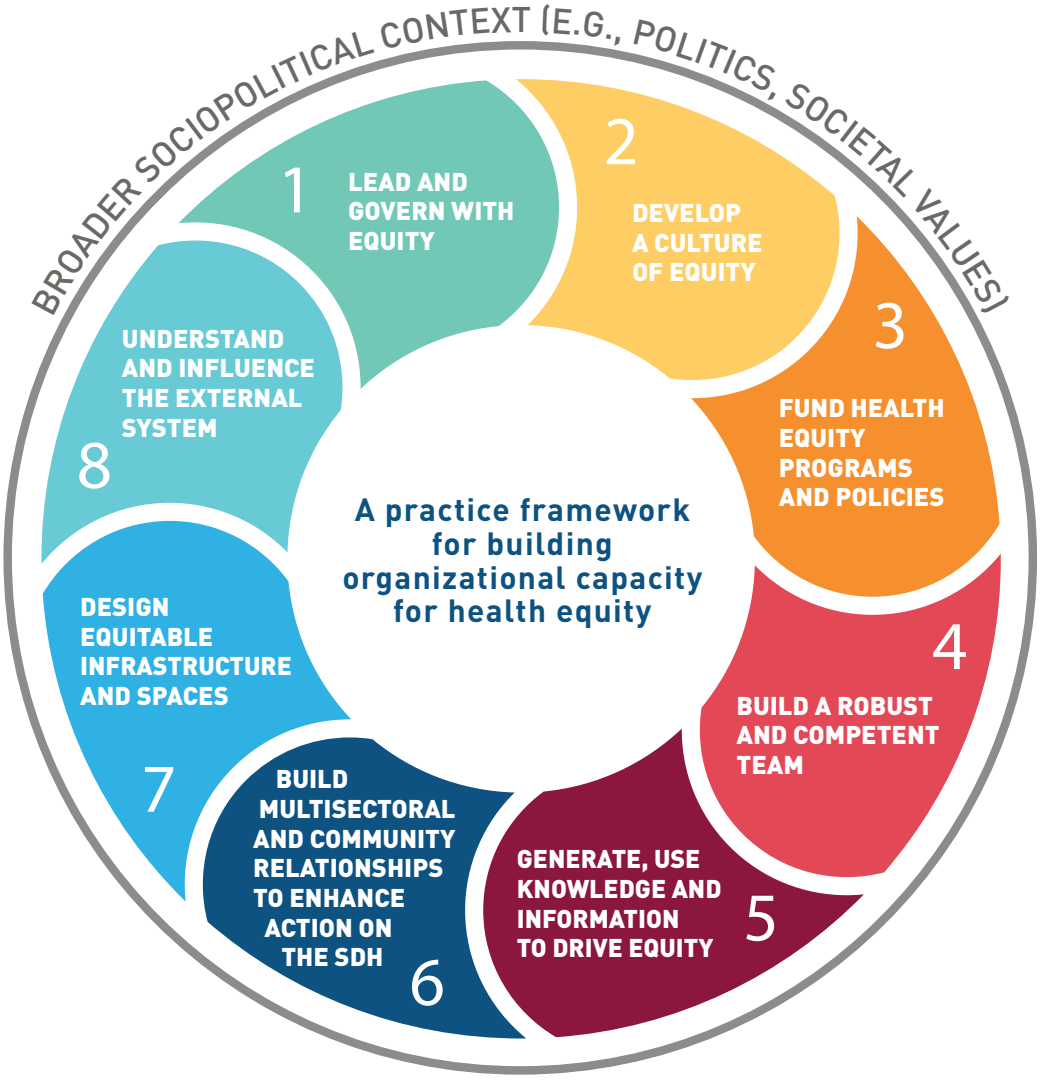
WHAT ASPECTS OF ORGANIZATIONAL CAPACITY DO PUBLIC HEALTH ORGANIZATIONS NEED TO PAY ATTENTION TO?

Of the various organizational frameworks that have been proposed, several are in use by public health organizations. In British Columbia, Canada, the Equity Lens in Public Health[13] project identified the importance of making health equity explicit in the mandates of organizations, including how the organization mobilizes data and is held accountable for health equity action.

In another example, Cohen and colleagues[12] proposed a conceptual framework for organizational capacity for public health equity action developed through a review of the literature and expert consultation with Canadian health equity champions. The framework by Cohen et al.[12] identified elements of the external and internal environment that together make up an organization's ability to act to improve health equity.

Lambton Public Health in Ontario, Canada, developed a framework with seven elements of organizational capacity that contribute to health equity action across three levels: individual practitioner, organization and system. The Lambton framework draws on the work of Meyer et al.[18] and has been piloted with several program teams within their organization. In the United States, the Bay Area Regional Health Inequities Initiative developed a framework of workforce competencies and organizational characteristics for addressing health inequities,[19] again emphasizing the need for capacity at multiple levels.

Here, we describe a practice framework that adopts eight aspects of public health capacity described by Meyer and colleagues.[18] The tool is designed to help support organizations integrate health equity into their strategic and operational priorities.[12,13,15,17–19] To make the framework easier to understand and use, we have described these eight components as discrete elements in the pages that follow.



As you review the framework, however, it is important to consider that organizations are complex and dynamic systems. In addition, it is worth noting that all eight elements are interrelated and influence each other (see Box 1). For example, if you improve how affected communities exercise power in decision-making, this can have an impact on organizational partnerships, as well as how the organization envisions its governance. Organizations need to develop mechanisms to monitor how decisions in one area of organizational capacity influence others.

Box 1: Complexity and organizational capacity and change

Organizations are complex systems with many layered and interdependent parts that are constantly adapting to each other and to the external environment.[24,25]

As complex adaptive systems, organizations[25,26]:

- have many interacting elements that constantly react to each other, which influences the entire network;
- can self-organize and adapt in specific parts of the system without centrally driven change;
- demonstrate emerging patterns based on collective actions of different parts of the system;
- are such that components of the system are not always aware of the entire system and act on what is known to them;
- draw on the past to inform present behavior; and
- respond to external pressures in different ways across the organization.

This calls on organizations to be attuned to change at multiple levels: individual, process and organizational (Diane LeBlanc, September 17, 2018).[27] These levels vary based on their realm of influence within the organization:

- Organizational: Strategy, values and behaviours and leadership
- Process: How the organization functions and the systems that at in place to support consistent practice
- Individual: The skills, knowledge and job specifications of individuals

A process-oriented approach to change will strive to build consistent capacity for health equity across levels and sub-parts of the organization. Strategies that address multiple layers and build in constant monitoring and learning will likely have a longer-lasting impact.

1 LEAD AND GOVERN WITH EQUITY

Governance is described as how "societies or organizations make decisions, ascertain who should be involved in these decisions, and determine how accountability for actions can be ensured."[28(p12)] It can also be thought of as "all forms of organized decision-making with shared social goals."[9(p67)] Governance focuses on the "distribution, exercise and consequences of power"[29(p897)] and is a central area of consideration for public health organizations looking to improve their capacity to address health equity.

Governance is closely related to and influenced by the values and beliefs about how things work in a specific organization or context.[30] Through governance, organizations make decisions about what actions we take or don't take on an issue. At the governance and leadership level, organizational priorities and norms are established and translated into policy, strategies and values.

Governance for health equity involves[13,19,20,28]:

- organizational commitment to address health equity, which is seen in vision and mission statements, values and strategic plans;
- formal governance bodies (such as boards, committees and advisory groups) that are guided by principles of equity, cultural safety, inclusion and anti-oppression;
- shared decision-making with partners and affected communities; and
- clear accountability through explicit goals, targets and processes.

Organizations can directly involve partners and community members in governance and decision-making in multiple ways:

- As members on boards of directors of the whole organization[15]
- Through participation in project-level advisory groups
- Through ongoing, reciprocal engagement processes across the organization.

This involvement puts power back into the rightful hands of communities to make decisions that influence their lives.

Leadership at both the individual and organizational levels propels and supports health equity action;[31,32] individual leadership transformed into organizational leadership, however, allows for sustained action. This can be enabled through organizational structures and processes.[31] For example, leadership transitions need to support health equity to be at the core of the new leadership.

A significant challenge for mainstream organizations will be to truly recognize and value diverse forms of leadership, particularly leadership from people who bring lived experience to their role as leaders. Across distinct, culturally aligned leadership, leadership-related practices are collective in nature and embody approaches of collaborative problem-solving, and are based on relationships and communities.[33,34] While culturally aligned leadership provided by many marginalized peoples usually reflects the kind of leadership required to improve equity, it is often not recognized or valued within mainstream organizations. Decolonizing change agent Lesley Varley, for example, notes, "Mainstream organizations are currently hiring Indigenous leaders for their knowledge, skills, and for expertise, but measure Indigenous leaders by mainstream values, norms and behaviours."[34(p976)]

2 DEVELOP A CULTURE OF EQUITY

Organizational culture is a significant reason why organizational change succeeds or fails.[24] According to Schien,[35] organizational culture includes:

- visible culture such as structures, processes and behaviours;
- values embedded in strategies, goals and ideals; and
- assumptions and unconscious beliefs that are the fundamental basis for values and (in)action.

Organizational values such as social justice, solidarity, reciprocity and inclusion support health equity action.[12,31,36] While many organizations include these values in their official organizational statements, there is often a gap between expressed values and the visible structures, processes and organizational behaviours. To close this gap, organizations have to engage in active reflection and discussion about values and the behaviours, practices and policies that mirror stated values. This is especially important for organizational leaders who set the tone and direction for the organization.

The values of the organization are influenced by the values and ideologies of the individuals within them and the broader society within which organizations operate. Leaders who embody values of social justice and solidarity shape and contribute to individual and organizational action to advance health equity.[14,31,32,36,37] Indeed, the values and ideologies held by individual leaders influence the approach taken to address the social determinants of health and health inequities.[14] By role modeling health equity action and a willingness to bring their experience to discussion tables, senior leaders in particular can play an important role in making expressed values visible. This strategy signals to others that health equity is a priority for the organization.

An organizational culture that centres learning, innovation and risk-taking supports health equity–oriented change and action.[19,31,34,38] This culture provides dedicated time to reflect on practice and integrate multiple ways of knowing and ways of working that challenge existing norms. Open, multidirectional communication across the organization — and with the community — strengthens learning and results in action to improve health equity.[19,28]

3 FUND HEALTH EQUITY PROGRAMS AND POLICIES

Resources are instrumental to an organization's ability to effectively address health equity.[15] Within organizations, social determinants of health and health equity programs and initiatives have to be sustainable and adequately funded.[39] Not only do public health organizations and programs require sufficient and stable resources, the health equity activities that are funded must also be those that are most likely to reduce health inequities.

When we talk about fiscal and economic resources, we must also think about the means through which these resources are measured and managed, for example through budgets, revenue and in-kind assets. As such, budget analysis and planning tools assist organizations to make decisions on the appropriate types and levels of funding or resource allocation needed. Standard budget processes can be adapted to include an explicit equity analysis that ensures resources are appropriate to address the depth of health inequities.[15]

For example, the US city of Portland, Oregon, uses a budget equity assessment tool as a guide for assessing the benefit or burden of budget requests to communities.[40] The tool supports the city to do the following things:

- Use an asset management approach to achieve more equitable service levels across communities and geographies.
- Track and report on service levels and investments by community and geography, including expanding the budget mapping process
- Assess the equity and social impacts of budget requests to ensure programs, projects and other investments to help reduce disparities and promote service level equity, improve participation and support leadership development.
- Identify whether budget requests advance equity, represent a strategic change to improve efficiency and service levels and/or are needed to provide for basic public welfare, health and/or meet all applicable national and state regulatory standards. [40(p1)]

4 BUILD A ROBUST AND COMPETENT TEAM

The knowledge, skills and attitudes of staff and how they are able to use their competencies in pursuit of health equity goals is critical to an organization's ability to address health inequities.

Skilled and committed staff across the organization are needed to drive health equity–oriented change. Staff competencies will vary based on roles (see examples in Box 2) and generally call for staff to develop structural competencies. A structural competency approach provides staff with the ability to analyze and understand health and social outcomes and experiences as part of broad systems and structures of power and privilege.[41–44] Organizations can draw on partnerships with external organizations and academic institutions that support workforce development to bolster their own staff capacity.

Box 2: Selected health equity competencies

- Health equity and social justice
- Structural, Indigenous, social, ecological and political determinants of health
- Anti-racism and cultural safety with attention to the realities and rights of specific groups (e.g., Indigenous cultural safety)
- Leadership
- Policy analysis, development and implementation
- Advocacy and political analysis
- Communications
- Partnership and network development
- Equity-oriented data analysis

Individual staff competencies are not sufficient on their own to effect or sustain change efforts. In concert with individual staff capacity, organizations need human resources practices that:

- incorporate equity principles from hiring through to retention and promotion to ensure a diverse and equitable workforce across positions and throughout the organizational hierarchy;
- develop, promote and reward qualifications for new and existing staff that reflect the skills and attributes required to address health inequities;
- build staff knowledge and skill to address health inequities through ongoing mentorship, supervision and training;
- promote accountability by integrating health equity into performance management expectations and processes; and
- provide a living wage across all staff positions, as well as employment security and continuing education.[45]

Health equity has to involve everyone and at the same time needs a clear structure and leadership to steward health equity capacity-building and strategy.[15,46,47]

5 GENERATE AND USE KNOWLEDGE AND INFORMATION TO DRIVE EQUITY

Health equity action, programs and policies require effective and robust monitoring, surveillance and reporting systems with equity-oriented measures and analysis.[13,48] Standard epidemiological norms that focus on average or aggregate measures often mask inequities and fail to interrogate the systems that create inequities.[49]

Equity-oriented health status reporting includes the following elements[50,51,39]:

- Participatory practices that help community members engage in decisions on what data is relevant and how best to collect and share community data and information
- Equity stratifiers related to income, disability, race, sexual orientation and gender identity and the related systemic drivers of classism, ableism, racism, homophobia, heterosexism and transphobia
- An indicator framework for health equity analysis that addresses gaps in indicator data (e.g., stigma, access to services) and capacity to collect and analyze data, as well as the limitations of the data
- An intersectional analysis
- Capacity to gather and analyze required additional data in situations of health crisis

Broader indicators and approaches that monitor the social determinants of health — beyond downstream indicators — are needed as part of surveillance systems. These approaches fix our gaze and actions on social, cultural, economic and political systems instead of resting on individuals and communities negatively impacted by oppressive systems.[52] For example, Chae et al.[53,54] use a spatial measure of "area racism"[53(p1)] to analyze the impact of systemic racism on birth weights and infant mortality. This approach firmly places the focus on how varying levels of racism in communities influence health and point to the need for community-level action.

Broad and diverse knowledge should be used to inform health equity action.[42,55] More specifically, public health organizations benefit from an approach to health equity that considers multiple types and sources of evidence. Communities, for example, are an essential source of knowledge about assets, capabilities, needs and solutions. Further, organizations have to acknowledge that policy decisions are informed by more than scientific evidence.[56–58] As stated by a former health minister, "Evidence doesn't dictate health policy, never has and possibly never will. It backs up policy directions."[56(p141)] As such, it is important that the public health sector includes knowledge and perspectives related to politics, advocacy and network communication as part of our approach to decision-making and organizational change. Organizations will also need to discern what types of knowledge and information will support change for various actors and sectors of the system.

In order to facilitate action and strengthen accountability, organizations require access to population-level data that integrates health equity indicators across a wide range of public health indicators and issues. This required data and analysis, in turn, can be facilitated by internal and cross-organizational structures such as public health observatories.

Within organizations, processes to share and use health equity research, data, information and tools internally and externally with partners and communities are essential.[19,59–62]

An organizational environment that supports ongoing learning through robust knowledge sharing will enable organizational actors to integrate new knowledge into everyday practice.[22,63]

6 BUILD MULTISECTORAL AND COMMUNITY RELATIONSHIPS TO ENHANCE ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

Public health action on the structural and social determinants of health and health inequities is improved when public health organizations partner with non-health sectors and affected communities. Strategic intersectoral partnerships support public health participation in long-term, policy-oriented action.[30,61,64,65] In addition, multisectoral partnerships with governmental and non-government organizations support public health organizations to act on specific social and structural determinants of health. Through reciprocity, these relationships benefit all partners.

Community engagement and participation are mechanisms for transformative practice where power is shared with communities. This is especially important for communities that are less likely to have a say in decisions that affect their lives and have limited access to decision-makers and decision-making processes.[66]

Community engagement that is built into organizational processes supports this approach and results in dedicated time and resources for partnership and network development. Organizations will ensure that valuing efficiency does not suppress the community participation, involvement and empowerment that is essential to health equity and system sustainability over the long term. Instead of treating engagement and partnerships as burdensome and time-consuming additions, for example, work plans can include partnership-building and community engagement as specific and essential components of policy processes, programs, projects and initiatives with adequate time and resources allocated.

As noted by OCI learning circle members,[50,51] community engagement requires the following actions:

- Identification of and engagement with groups experiencing marginalization and disadvantage to keep health equity at the forefront
- Respectful systems for engagement to redress current practices that are tokenistic and can be negative for the community members who participate in engagement processes
- Public health participation in existing community tables while creating new engagement structures
- Organizational training on when, how, who and at what level to engage with community members
- Community-based participatory approaches to identify the specific needs of communities and subpopulations (A universal approach to engagement can be problematic, as it can unintentionally exclude some groups while benefitting others).
- Acknowledgment that change related to community engagement is incremental

7 DESIGN EQUITABLE INFRASTRUCTURE AND SPACES

Organizational infrastructure influences an organization's capacity for health equity and includes both physical and virtual infrastructure.

Inclusive and accessible physical spaces support access and create a sense of belonging, safety and values that are aligned with health equity.[15] Moreover, the extent to which staff have the resources (e.g., hardware, connectivity, software, telecommunications tools) needed to effectively engage in health equity change influences organizational capacity. There may be program-specific resources that allow for more or less equitable practices. For example, in disaster or emergency management, we must consider how equity is considered in terms of resource availability and prioritization of emergency supplies.

Technological infrastructure impacts an organization's ability to reach the population and to support internal learning and decision-making.[67] In some organizations, public health practitioners are not able to access the sort of digital tools that can support knowledge exchange on health equity within their organizations.[68] This limited access diminishes the capacity of staff to engage in a dynamic learning environment with peers. To facilitated learning, organizations can create more open and inclusive practices that allow for interorganizational learning and exchanges.

8 UNDERSTAND AND INFLUENCE THE EXTERNAL SYSTEM

Organizations are part of larger systems and are located in specific geopolitical jurisdictions and contexts. An organization's structure and relationships within the broader system (e.g., federal, provincial/territorial, regional, local) provide specific conditions within which the organization operates, a connection that calls for a specific understanding of how this impacts organizational capacity. Elements that contribute to the broader system include the following:

- Regions (geography) covered and their size: Organizations may be covering regions across multiple jurisdictions, which will require the skill to navigate various decision-making systems and priorities.
- Geography: Specific geographies yield unique health equity challenges and opportunities for organizations. Depending on their settings, organizations will have to navigate these specificities in urban, rural, suburban, remote and Northern communities. This also includes mobility patterns and service provision patterns, among other factors.
- Population and demographics: Community demographics will highlight different areas of focus for organizations. Considerations include race, ethnicity, income, culture and language, among others.

Meyer et al.[18] note that system boundaries and size change slowly. However, there have been ongoing reorganizations to public health across Canada that have generally weakened the public health system.[69,70] As a result, organizations have to develop the skills and processes to negotiate, influence and adapt to new systems. Organizations must also know the systems and communities within which they are situated. Strategies such as community health assessments, environmental and media scans[71] can assist with this process.

THE SOCIAL AND POLITICAL CONTEXT AS DRIVERS OF INEQUITY AND ORGANIZATIONAL CAPACITY

The social and political context, including societal norms and values, are fundamental (structural) determinants of health inequities.[8] Moreover, political commitment and government resource allocation for health equity–related policies influence health outcomes[72,73] and serve as enablers for organizational action.[58,74] The presence of legislation and policies on the social determinants of health and health equity are also enablers of organizational capacity.[12]

Organizational capacity is further influenced by emerging health threats, epidemiological conditions and the evidence that is available at a given time; each of these factors can focus attention on particular social determinants of health and health equity concerns.[17,18] Another consideration is the degree to which public support exists for health equity–oriented action. Real or perceived support can bolster the desire for organizations to act to reduce inequities and create the case for building capacity.

Just as the social and political context shape health and health inequities, so too do they influence the actions of organizations. The external context provides an authorizing or action-curtailing environment that organizations and the individuals within them read and react to.[31,58] As Smith[58(p358)] notes, "actors' readings of political and social 'contexts' appears to influence their actions and interactions; they are, therefore, doing more than passively interpreting external 'contexts.'" While there is an established body of evidence and lived experience that shows persistent health inequities[8,75,76] and an awareness on the part of decision-makers,[37,56] change in practice has been slow to follow.[49,56,77]

According to Baum and colleagues,[56] former Australian health ministers indicated that the development of social determinants of health policies was supported by cross-portfolio structures, policy entrepreneurs and evidence. These health ministers noted that policy formulation was "hindered by the complexity of SDH policy, the dominance of medical power and paradigms and the weakness of the policy community advocating for SDH."[56(p138)]

Health inequities are ultimately a result of political and policy decisions or indecisions.[6,77] As such, public health organizations need to develop a stronger 'read' of how political[56,78,79] and policy contexts influence health. This reckoning points organizations towards approaches that actively engage with power, politics and decision-making beyond their doorsteps.[6–9,49,80] It also pushes these organizations to reimagine political, economic and social policies and systems that generate more equitable health and social outcomes.

CONCLUSION

In this document, we outline key aspects of organizational capacity that support action on the social determinants of health to improve health equity. Addressing these with courage, creativity and innovation grounded in social justice will enhance public health organizations' ability to act effectively to improve health equity.

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The Organizational Capacity for Health Equity Initiative (OCI) explores issues related to organizational capacity and organizational change, such as building change together, communicating change, values, governance, psychological safety and organizational assessments.

Visit the NCCDH website at www.nccdh.ca for more OCI resources.

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